



DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Delays in Processing
Community-Based Patient
Care at the Orlando VA
Medical Center

Florida



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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection at the Orlando VA Medical Center (facility), Florida, after receiving a request from Congressman Bill Posey to review allegations received from a constituent related to community-based patient care. Specifically, the complainant alleged

- A patient died while experiencing a long delay in the approval for non-VA care coordination (NVCC),
- The facility failed to timely approve and process NVCC consults and coordinate care, and
- The delays resulted in adverse clinical outcomes.

The patient referenced in this report died prior to undergoing aortic valve surgery for *asymptomatic* severe aortic stenosis (AS).¹ The OIG did not substantiate that the death occurred as a result of a long delay in the approval for NVCC services.

The patient was first diagnosed with moderate AS in 2015. According to repeat test results in fall 2016, the AS had progressed and should have been classified by the treating cardiologist as severe. However, the cardiologist who evaluated the patient in 2016 documented in the patient's electronic health record that the AS was moderate. The treatment for asymptomatic, moderate AS is typically surveillance. The treatment options for patients with severe AS who do not exhibit signs or symptoms of the disease process range from close surveillance to surgery.² Although the cardiologist did not accurately document the progression from moderate to severe AS, the cardiologist did schedule the patient for an annual follow-up exam in fall 2017. The OIG was unable to determine whether that was a reasoned decision by the provider after recognizing that the patient's AS had progressed or not. However, the OIG notes that it was within the acceptable treatment options. A second cardiology provider evaluated the patient in 2017, noted that the patient's severe AS had slightly progressed, and referred the patient to an NVCC thoracic surgeon for further evaluation.

¹ Aortic stenosis is the most common valvular heart disease in developed countries. It is a narrowing of the valve located between the heart and the aorta, called stenosis, which may occur as a result of a congenital defect, build-up of calcium on the valve, or as a complication of rheumatic fever.

² Nishimura RA, Otto CM, Bonow RO, et al. *2014 AHA/ACC guideline for the management of patients with valvular heart disease: executive summary: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines*. J Am Coll Cardiol 2014;63:2438–88.

The OIG did not find a long delay between the referral for surgery and evaluation by a thoracic surgeon although 46 days elapsed between the time the NVCC provider entered a request for additional services and the acknowledgement of this request by the facility's authorizing official.

The OIG evaluated whether the patient exhibited signs and symptoms associated with his severe AS during the 2016 and 2017 surveillance period. The patient had both complex cardiac and pulmonary disease, which would make differentiating an etiology for certain signs and symptoms associated with AS, such as shortness of breath, challenging, even to the most experienced providers.

The patient was evaluated by a primary care provider and a pulmonary clinic nurse practitioner during the time frame at issue. The OIG concluded that the pulmonary clinic nurse practitioner who evaluated the patient approximately six months prior to the patient's 2017 death noted shortness of breath and should have considered whether the patient's shortness of breath was an indication that the patient's AS had become symptomatic. This consideration may have led to an earlier appointment with the cardiologist and possibly an earlier evaluation for surgery.

As noted, for this patient, the involved facility staff generally complied with consult processing and scheduling guidelines except for the 46-day period that elapsed between the time the NVCC provider entered a request for additional services and the acknowledgement of this request by the facility's authorizing official. For other patients who were referred for NVCC consults in 2017, the OIG substantiated delays in their approval and processing. The OIG found that an increase in the number of consults coupled with the limited number of Integrated Health Service and Office of Community Care staff contributed to delays in the management of NVCC consults at the facility.³ Additionally, the OIG identified problems with assigning and adhering to clinically indicated dates⁴ by referring providers and Integrated Health Service staff. The OIG found that the lack of a fully implemented and automated tool to assist with care coordination increased the possibility of disruptions in the coordination of care for NVCC patients.

While the OIG did not identify adverse clinical outcomes for the patients reviewed as a result of delayed NVCC consult processing, the OIG recognizes that these delays could cause frustration, confusion, or disturbances in a veteran's activities of daily living.

The OIG made six recommendations to the Facility Director:

³ The Integrated Health Service is responsible for coordinating the facility's community-based patient care consults; the Office of Community Care is responsible for the authorization of funds and payment for community-based patient care.

⁴ The clinically indicated date is the earliest date that the requesting provider determines care is clinically appropriate. VHA Directive 1232 (1), *Consult Processes and Procedures*, August 24, 2016, amended September 23, 2016.

- Ensure that the nurse practitioner referenced in this report has appropriate competencies to perform current duties.
- Implement a reliable tool for coordinating the NVCC process and monitor the tool for consistency.
- Conduct a compliance review of the clinically indicated date used by providers referring patients to Integrated Health Service to determine adherence to Veterans Health Administration Directive 1232(1), *Consult Processes and Procedures*, and implement a plan for improvement if warranted.
- Ensure that NVCC appointments are scheduled within 30 days of the clinically indicated date and that performance is monitored.
- Conduct a review of Integrative Health Service workload demand and available staff and take action, as appropriate, to ensure staffing allows for consults to be acted upon within Veterans Health Administration consult timeliness standards.
- Implement a process for measuring the timeliness of approvals for requests for additional services and monitor compliance.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with the findings and recommendations and provided acceptable action plans. (See Appendixes B and C, pages 22–26, for the Directors’ comments.) The OIG will follow up on the planned actions until they are completed.



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Abbreviations

AS	aortic stenosis
Choice	Veterans Choice Program
CID	clinically indicated date
cm ²	centimeters squared
COPD	chronic obstructive pulmonary disease
CT	computed tomography
EHR	electronic health record
FY	fiscal year
IHS	Integrated Health Service
NP	nurse practitioner
NVCC	non-VA care coordination
OIG	Office of Inspector General
OCC	Office of Community Care
RN	registered nurse
RAS	request for additional services
VERC	Veterans Engineering Resource Center
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network



Introduction

Purpose

The VA Office of Inspector General (OIG) conducted a healthcare inspection at the Orlando VA Medical Center (facility), Florida, after receiving a request from Congressman Bill Posey to review allegations received from a constituent related to community-based patient care.

Background

The facility is part of Veterans Integrated Service Network (VISN) 8, serves veterans in Central Florida, and is composed of the Lake Nona facility located in Orlando and clinics providing outpatient care in Lake Baldwin, Viera, Daytona Beach, Clermont, Kissimmee, Tavares, and Deltona, Florida. The Lake Nona facility, located near the University of Central Florida College of Medicine, became operational in 2015 and is located on a 65-acre campus. In fiscal year (FY) 2017, the facility served 113,284 patients and had a total of 344 operating beds, including 108 inpatient beds, 116 domiciliary beds, and 120 community living center beds.

Aortic Stenosis

Aortic stenosis (AS) is the most common valvular heart disease in developed countries. It is a narrowing of the valve located between the heart and the aorta, called stenosis, which may occur as a result of a congenital defect, build-up of calcium on the valve, or as a complication of rheumatic fever. Providers typically use echocardiography to diagnose and monitor the progression of AS.⁵

Patients generally benefit from aortic valve replacement procedures if they have severe AS and symptoms, such as chest pain, shortness of breath, or syncope, associated with the stenosis. AS is considered severe if the valve area is low and the difference in the pressure across the valve and the velocity of blood flowing through the valve is high.⁶ Patients with one or more indications of

⁵ Echocardiography is the use of sound waves converted to moving images depicting the heart that may be viewed on a monitor. <https://www.mayoclinic.org/tests-procedures/echocardiogram/about/pac-20393856>. (The website was accessed on June 6, 2018.)

⁶ Severe AS is defined as a peak aortic jet velocity >4.0 m/s or mean gradient >40 mmHg and usually having with aortic valve area (AVA) ≤ 1.0 cm². See Bonow RO, Brown AS, Gillam LD, Kapadia SR, Kavinsky CJ, Lindman BR, Mack MJ, Thourani VH. *2017 Appropriate Use Criteria for the Treatment of Patients with Severe Aortic Stenosis*, Journal of the American College of Cardiology 2017;70:10.

severe AS on echocardiography who are symptomatic should be referred for aortic valve replacement. “[T]here are few diseases in cardiology more lethal than severe symptomatic AS.”⁷

If a patient is asymptomatic, the decision whether to treat surgically is much more complex. When asymptomatic, patients may be monitored with serial echocardiography. The rate of progression to symptoms is varying and unpredictable. Current guidelines recommend valve replacement for patients with asymptomatic severe AS who have a diminished ejection fraction. An ongoing surveillance approach is adopted for most asymptomatic patients with surgical intervention planned once symptoms appear.⁸

Community-Based Patient Care

Community-based patient care is purchased by the Veterans Health Administration (VHA) for eligible patients when VA facilities cannot provide care and services, when a patient cannot safely travel due to medical reasons, when care cannot be provided within 30 days of the clinically indicated date (CID), or when care cannot be provided due to geographic inaccessibility.⁹

Community-based patient care includes the Veterans Choice Program (Choice) and non-VA care coordination (NVCC).¹⁰ Choice was established by the Veterans Access, Choice, and Accountability Act of 2014. Under this program, VA contracts with third-party administrators to coordinate purchased care from community-based care providers. NVCC refers to the process through which VA purchases care from community-based care providers without the involvement of Choice third-party administrators.¹¹ A consult and pre-authorization for care in the community are required for services rendered through Choice and NVCC.

At the facility, Integrated Health Service (IHS) is the department responsible for coordinating community-based patient care consults. The Office of Community Care (OCC) is responsible for authorization of funds and payment for community-based patient care.

⁷ Blase A. Carabello, “Aortic Stenosis: A Fatal Disease with But a Single Cure,” *JACC:Cardiovascular Interventions* 1, no. 2 (2008): 127-128.)

⁸ Ejection fraction is the measurement of how much blood is being pumped out of the heart chambers. <https://my.clevelandclinic.org/health/articles/16950-ejection-fraction>. (This website was accessed December 18, 2018.)

⁹ The clinically indicated date is the earliest date that the requesting provider determines care is clinically appropriate. VHA Directive 1232 (1), *Consult Processes and Procedures*, August 24, 2016, amended September 23, 2016; VHA Directive 1232(1); VHA Directive 1230, *Outpatient Scheduling Processes and Procedures*, July 15, 2016.

¹⁰ The Veterans Access, Choice, and Accountability Act of 2014 expanded the eligibility for, and number of options that patients have for receiving community-based care to ensure timely access to care; VHA Directive 1232(1).

¹¹ VHA Directive 1601, *Non-VA Medical Care Program*, January 23, 2013.

Consults

A consult is a request for clinical services on behalf of a patient. The consult process provides a method of coordinating patient care among different services and includes an automatic electronic health record (EHR) notification feature to notify the requesting provider (alert) of actions or changes made to the consult. Consults ordered by a requesting provider are for clinical evaluation or management of a specific health issue. VA facilities use a consultation package in the EHR to enter, approve, schedule, and document information on a variety of consults including outpatient, inter-facility consultation, and community-based patient care.¹²

IHS Process for NVCC¹³

Multiple steps and many people are involved in processing consults and the coordination of NVCC consults. As stated by OCC, “[t]he goal is to authorize care in such a way that treatment proceeds as smoothly as possible for the Veteran until treatment is completed. The evaluation and treatment of the Veteran’s condition should include all medically necessary services that a prudent provider would need to assure safe and effective care.”¹⁴ IHS uses EHR-based consult status reports to follow the aging of consults, and registered nurse (RN) and administrative support assistant staff who use tracking spreadsheets to assist with coordination of care.¹⁵

Initial NVCC Request—Pending Status

A consult is classified on receipt as being in pending status during which time an IHS provider determines the patient’s administrative eligibility for NVCC and provides a clinical review of the consult. The requesting provider designates urgency by identifying the consult as stat or routine.¹⁶ In addition to determining the urgency of each request, the requesting provider should determine the clinically appropriate timeframe in which the care needs to be provided, and enter a date into the CID field on the consult. “The CID determination is made based upon the needs of the patient and should be at the soonest appropriate date.”¹⁷

¹² VHA Directive 1232(1).

¹³ The focus of the OIG review in this report is on NVCC. The facility started to transition away from new Choice consults beginning in June 2017.

¹⁴ A Community Care, *Secondary Authorization Requests (SAR) Process Guide*, October 23, 2017.

¹⁵ EHR-based consult status reports are reports programmed to automatically run specific data on consult timeliness. An example would be a report that would show how many days had passed from the time a consult was entered until an appointment was scheduled.

¹⁶ Orlando VA Medical Center Policy No. 11-13, *Consultation Referral*, January 2, 2017. Stat consults are those with an immediate concern that need to be addressed within 6 hours and no later than 48 hours. Routine consults should be completed within 14 days.

¹⁷ VHA Directive 1232(1).

After review of the new NVCC consult, the IHS provider documents approval for the services to be provided in the community in order to fulfill the health care needs specified on the original NVCC consult.

According to VHA Directive 1231(1), the timeframe with which the IHS provider was required to act on pending consults was within seven calendar days.¹⁸ In June 2017, the Deputy Under Secretary for Health for Operations and Management notified VISN directors that the approval process must occur in two business days.¹⁹

Active Status

After an NVCC consult is approved, the consult shifts from pending to active status and the IHS provider alerts the IHS RN case manager and administrative support assistant to begin processing the consult. IHS staff prioritize their workload to first process consults identified as other than routine and those coming from specialty services that IHS has identified as high risk.²⁰ While the consult is in active status, action is taken by the IHS RN case manager and administrative support assistant, often simultaneously. The IHS RN case manager reviews the patient's EHR to confirm completion of tests or procedures that need to be done prior to provision of the requested services by the NVCC provider. In the event that tests are needed, the IHS RN case manager coordinates with the referring provider to ensure orders are placed. The IHS RN case manager also compiles a packet of the patient's relevant medical information to be sent to the NVCC provider.

The IHS administrative assistant contacts the patient to confirm that the patient would like to opt in for NVCC, contacts the patient to determine which NVCC provider the patient would like to see, alerts OCC staff of the provider selected, and requests an authorization for NVCC.²¹ OCC staff create an authorization, obligating funds for NVCC, and document the authorization on the consult. The administrative assistant sends the referral packet, including the authorization for payment from OCC and the medical records compiled by the IHS RN case manager to the selected NVCC provider. The NVCC provider is responsible for contacting the patient and scheduling the appointment. Facility managers expect the IHS and OCC teams to work together expeditiously to coordinate the patient's appointment for consults other than routine. Once the appointment is made, the consult is moved from active to scheduled status.

¹⁸ VHA Directive 1232(1).

¹⁹ Deputy Under Secretary for Health Operations and Management Memo, *Scheduling and Consult Policy Updates* (VAIQ#7798804), June 5, 2017.

²⁰ Higher-risk services are those that IHS has determined require more timely medical care due to the nature of the diagnoses. Examples include surgery, mental health, cardiology, and cardiothoracic surgery.

²¹ The Chief Business Office (CBO) has been consolidated under the OCC. At the facility, many employees still refer to this OCC as "CBO."

Scheduled Status

VHA Directive 1232(1) states a “consult should be in scheduled status within 14 days of date of consult order.”²² VHA Directive 1230 requires that appointments are scheduled and occur within 30 calendar days of the CID specified by the requesting provider or the date of the patient’s request for an appointment, the patient preferred date.²³

Consults remain in scheduled status from the time the appointment is made until the patient has been seen and VA receives and uploads documentation of the care provided.

Complete Status

Following the initial NVCC visit, records from the NVCC provider are sent to VA. Upon receipt of the records, the IHS RN case manager enters a summary of care in a Community Care Coordination Note and alerts the VA provider who ordered the consult. Records from the NVCC provider are scanned into the patient's EHR, where the VA health care team can view them. Attaching the scanned documents from the consulting NVCC provider to the EHR changes the status from scheduled to complete.

Requests for Additional Services

In some instances, after seeing the patient, the NVCC provider determines that additional tests or procedures are required that were not originally authorized. A request for additional services (RAS), also referred to as a secondary authorization request, is submitted by the NVCC provider for approval and authorization when a patient needs additional medically necessary services. An RAS is required to approve coverage for diagnostic or treatment services not included in the original authorization for the condition that was the focus of the referral to the community.

The approval language for NVCC consults is standardized at the facility (see Figure 1) and explicitly states that an RAS outside those services originally specified must be requested by the NVCC provider through the VA Fee Basis office within 48 hours of the initial visit.²⁴ NVCC providers may advise IHS staff of an RAS via phone call, but a written submission of the request is required. Once an RAS is received, the IHS RN case manager reviews and summarizes the request and alerts the requesting consult provider and the IHS provider. If it is determined that the request was covered under the initial authorization, no further approval or authorization is required and the NVCC provider is informed that the request has already been approved.

²² VHA Directive 1232(1).

²³ VHA Directive 1230.

²⁴ The template language indicates approval is to be given by the Fee Basis office which is now referred to as IHS.

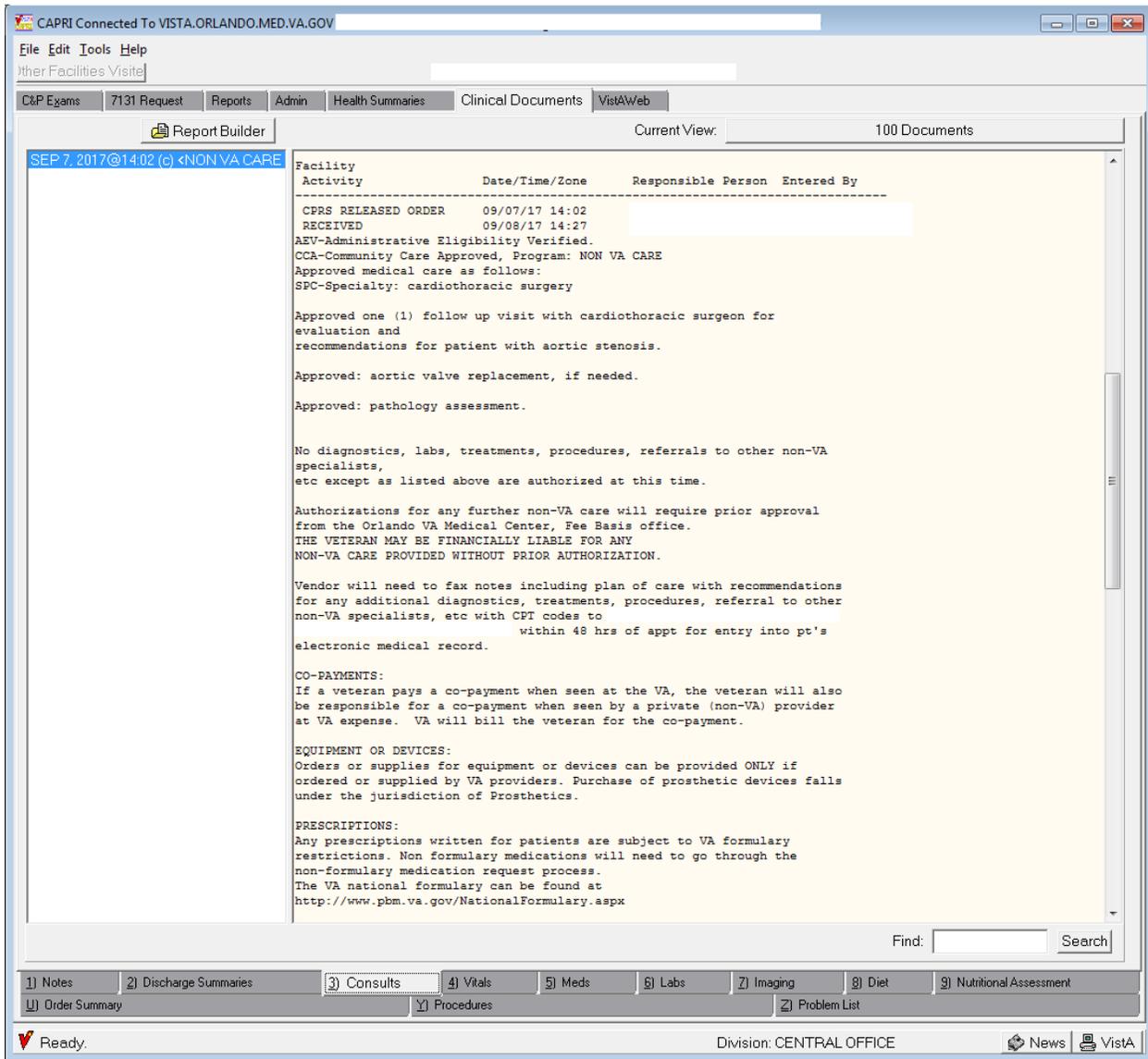


Figure 1: Screen shot of NVCC consult approval language
 Source: VA EHR in Compensation and Pension Record Interchange

If the requested service is available timely in the VA, the VA would provide the service unless there are clinical indications for the care to be provided in the community. IHS RN case managers have the capability of placing orders for certain tests or procedures. If the test or procedure requested in the RAS is not covered in the IHS nurse protocol orders, it must be ordered by the VA provider who originated the consult. That provider is alerted to the pending RAS by the IHS RN case manager. Once test results are available, the IHS RN case manager sends the results from those additional services performed at VA to the NVCC provider.

If the requested services are not available in VA or not available timely, the IHS RN case manager alerts the IHS provider to review the request. For routine requests that fit recognized

standards of care, the IHS provider may review and approve the request without consulting the requesting provider. If there are questions about the additional services requested, the IHS provider may consult with the requesting provider as the subject matter expert to determine the appropriateness of the additional service request. The requesting provider may give guidance but cannot approve NVCC. The IHS provider approves the requested services. The RAS is sent to the OCC, which generates the authorization for payment; the approval and authorization are sent to the NVCC provider.

The OIG found that VA lacked a policy specific to the timeframe in which NVCC RASs should be addressed. IHS staff reported that the facility's expectation for non-urgent NVCC RASs was to have IHS providers act on them within 5 days and process them within 14 days.

Allegations

On December 6, 2017, the OIG received an inquiry from Congressman Bill Posey's office requesting a review of a complaint from a constituent. In correspondence with the Congressman's office and interviews with the OIG, the complainant alleged

- A patient died while experiencing a long delay in the approval for NVCC,
- The facility failed to timely approve and process NVCC consults and coordinate care, and
- The delays resulted in adverse clinical outcomes.²⁵

The VISN responded directly to Congressman Posey on December 20, 2017, after receiving an inquiry from the Congressman concerning the allegations. The Congressman's office shared the VISN's response with the OIG on December 29, 2017. On January 4, 2018, the OIG reviewed the VISN response to the allegations and identified inconsistencies between the VISN response and documentation in the EHR as well as specific coordination of care concerns. On January 8, 2018, the OIG initiated a healthcare inspection.

²⁵ Within the context of this report, the OIG considered an adverse clinical outcome to be death, a change in diagnosis, a change in the course of treatment, or a significant change in a patient's level of care.

Scope and Methodology

The OIG initiated the inspection in January 2018 and conducted a site visit from March 20 through March 22, 2018. The complainant was interviewed on February 22, 2018, to better understand the allegations.

OIG team members met with the Facility Director, Chief of Quality Management, Associate Chief of Ambulatory Care, and Chief of IHS to discuss the scope of the review. Interviews were conducted with relevant staff at the National and VISN levels from VHA's OCC, administrative and clinical staff from IHS, cardiology and pulmonology providers, and a practice administrator and staff of an NVCC vendor.

The OIG reviewed the EHR of the patient at issue who was referred to an NVCC cardiothoracic surgeon and identified other patients with NVCC cardiothoracic surgery consults during the period of January 1, 2017, through October 31, 2017. An OIG RN and medical consultant reviewed the EHRs of the patients who had NVCC cardiothoracic surgery consults with delays to determine if delays were associated with adverse clinical outcomes.²⁶

Relevant documents were reviewed including VHA directives and handbooks; VHA's OCC resources/Toolbox; facility policies and procedures; provider credentialing, privileging, and competency files; job announcements; staffing turnover data; select medical literature including American College of Cardiology/American Heart Association guidelines; and facility organizational charts.

In the absence of current VA or VHA policy, the OIG considered previous guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issue(s).

The OIG substantiates an allegation when the available evidence indicates that the alleged event or action more likely than not took place. The OIG does not substantiate an allegation when the available evidence indicates that the alleged event or action more likely than not did not take place. The OIG is unable to determine whether an alleged event or action took place when there is insufficient evidence.

The OIG conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

²⁶ For the purpose of this review, delay was defined as an NVCC appointment falling more than 30 days past the CID or if the RAS was not approved within five business days.

Patient Case Summary

The patient, was in his/her 70s²⁷ with a history of chronic obstructive pulmonary disease (COPD)²⁸ and was evaluated for a heart murmur in 2015 with a transthoracic 3-dimensional echocardiogram. The echocardiogram supported the diagnosis of moderate AS with a valve area of 1.18 centimeters squared (cm²). The patient was scheduled for a follow-up echocardiogram in fall 2016, which revealed severe AS with a valvular area of 0.9 cm² and an ejection fraction of 65–70%.²⁹ Approximately one month later, a facility cardiologist described the patient as having asymptomatic, moderate AS. The patient had an electrocardiogram performed at that visit, which demonstrated a right bundle branch block, new since 2015.³⁰ The patient was scheduled for a routine follow-up echocardiogram in one year. The patient was instructed to call the cardiologist immediately if chest pain, shortness of breath, syncope, or reduced exercise tolerance occurred.

In spring 2017, the patient presented to his/her primary care physician with cough and shortness of breath, and was diagnosed with an acute COPD exacerbation. Approximately one month later, the patient followed up with a nurse practitioner (NP) in pulmonary clinic for evaluation of the COPD and an abnormal computed tomography (CT) scan. The NP documented shortness of breath and cough attributable to allergies, and a normal lung examination. The CT scan of the chest described the patient's underlying emphysema, as well as a chronic opacity in the left lung. The opacity had slightly increased since the patient's last CT scan, but the CT scan did not disclose other new clinical findings. Approximately three months later, the primary care provider evaluated the patient during a routine visit. The primary care provider documented that the patient denied shortness of breath and that the patient's lungs were clear with mildly diminished breath sounds throughout.

In fall 2017, the patient received another regularly scheduled echocardiogram, which demonstrated slight progression of the patient's AS. The aortic valve area was 0.8 cm² and the ejection fraction was 60–65%. The following day, a second facility cardiology provider saw the patient, described the valve disease as severe, and referred the patient to an NVCC cardiothoracic surgeon. The next day, the patient was approved for one visit to a cardiothoracic surgeon, and

²⁷ The OIG uses gender neutral language to protect patients' privacy.

²⁸ Chronic obstructive pulmonary disease is a chronic health condition that can make it difficult to breath and includes emphysema and chronic bronchitis. The patient's COPD was being monitored with serial computed tomography scans since mid-2015.

²⁹ A normal ejection fraction (the amount of blood pumped out of the heart) is between 55 and 70%. <https://my.clevelandclinic.org/health/articles/16950-ejection-fraction>. (This website was accessed December 18, 2018.)

³⁰ A bundle branch block is a delay or blockage along the pathway that electrical impulses travel to make the heart beat. <https://www.mayoclinic.org/diseases-conditions/bundle-branch-block/symptoms-causes/syc-20370514>. (The website was accessed on June 8, 2018.)

aortic valve replacement as needed. The consult request included the template language that “[n]o diagnostics, labs, treatments, procedures, referrals to other non-VA specialists...except as listed above are authorized at this time.”

The EHR reflects that prior to seeing the patient, the NVCC cardiothoracic surgeon received relevant clinical information and studies regarding the patient six days after the consult was approved. Nineteen days later, the NVCC cardiothoracic surgeon saw the patient and stated that the patient needed a cardiac catheterization and a CT of the chest, abdomen, and pelvis prior to surgery.³¹ Because those tests were available through VA, VA informed the NVCC surgeon the patient would complete the studies at VA. The patient died twenty days later. An autopsy was not done, but the patient’s death certificate listed the cause of death as AS, along with atherosclerosis, hypertension, and hyperlipidemia. Approximately 26 days after the patient’s death, an IHS provider acknowledged receipt of the cardiothoracic surgeon’s request for additional testing.

³¹ Cardiac catheterization is a procedure that involves the insertion of a long thin tube (catheter) into an artery or vein in the groin, neck or arm; the catheter is threaded through the blood vessel(s) to the heart. <https://www.mayclinic.org>. (The website was accessed on June 8, 2018.)

Inspection Results

Issue 1: Alleged Patient Death and Delays in NVCC Consult Approval

While the OIG substantiated that the patient died prior to undergoing surgical treatment for asymptomatic severe AS, the OIG did not substantiate the death occurred as a result of a long delay in the approval for an NVCC consult.

Initial Aortic Stenosis Diagnosis and Referral to NVCC

The patient was first diagnosed with moderate AS in 2015. According to repeat test results in 2016, the AS had progressed and was classified severe. The cardiologist who evaluated the patient in 2016 documented the patient's AS as moderate although the test results indicated the AS was severe. The cardiologist arranged for the patient to return for another appointment in one year and told the patient to call if certain signs and symptoms occurred. The Chief of Cardiology at the facility, when interviewed, indicated that the cardiologist who evaluated the patient in 2016 inappropriately classified the patient's AS as moderate rather than severe.³² A second cardiology provider who evaluated the patient in 2017 noted that the patient's severe AS had slightly progressed and referred the patient to an NVCC thoracic surgeon for further evaluation.

Asymptomatic patients with AS may be monitored with serial echocardiography; the rate of progression to symptoms is varying and unpredictable. Although current guidelines recommend valve replacement for patients with asymptomatic severe AS who have a diminished ejection fraction, ongoing surveillance is adopted for most asymptomatic patients, with a surgical intervention planned once symptoms appear.³³ The patient's ejection fraction was within normal limits in 2016 and 2017. Based on available information in the patient's EHR (including the normal ejection fractions), the OIG concluded that surveillance rather than a thoracic surgery referral in 2016 was a reasonable treatment option.

The OIG did not find a long delay between the referral for surgery and evaluation by a thoracic surgeon although 46 days elapsed between the time the NVCC provider entered a RAS and the acknowledgement of this request by the facility's authorizing official.

2017 Pulmonary Clinic Visit

The OIG evaluated whether the patient exhibited signs and symptoms associated with his severe AS during the 2016–2017 surveillance period. The patient had both complex cardiac and

³² The treating cardiologist died shortly after seeing the patient, so the OIG was not able to question the cardiologist about classifying the condition as moderate and not severe.

³³ Nishimura RA, Otto CM, Bonow RO, et al. 2014 AHA/ACC guideline for the management of patients with valvular heart disease: executive summary: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines. *J Am Coll Cardiol* 2014; 63:2438–88.

pulmonary disease, which would make differentiating an etiology for certain signs and symptoms associated with AS such as shortness of breath challenging, even to the most experienced providers.

Approximately six months before the patient died, in spring 2017, the patient saw an NP in the pulmonary clinic. The NP documented that the patient had shortness of breath but attributed it to allergic rhinitis. When interviewed, the NP stated that referring the patient back to cardiology to evaluate the shortness of breath as a symptom of worsening AS had not been a consideration, but, in retrospect, it might have been appropriate. The NP believed that he/she had adequate training to treat patients with these conditions.

While the NP's note was co-signed by a staff pulmonologist, the pulmonologist, when interviewed, admitted not seeing the patient on the day in question, but did not believe based upon a review of the EHR that a referral back to cardiology was needed. The pulmonologist said allergic rhinitis could have been the cause of the patient's shortness of breath if it exacerbated the patient's underlying lung disease.

The OIG concluded that while the patient's complexity of both cardiac and pulmonary disease made it challenging to differentiate an etiology for the onset of shortness of breath, the NP should have considered whether the patient's shortness of breath was an indication that the patient's AS had become symptomatic. This consideration may have led to an earlier appointment with the cardiologist and possibly an earlier evaluation for surgery.

NVCC Consult Processing Timeline

VHA requires facilities to provide patients with timely and clinically appropriate care.³⁴ In reviewing the NVCC consult processing timeline for this patient's case, the OIG found that

- One day elapsed between the time the facility cardiology provider entered an NVCC consult and the IHS provider approved the consult request for NVCC,
- Five days elapsed between the time the IHS provider approved the NVCC consult and OCC authorized funds,
- Twenty-six days elapsed between the time the facility cardiology provider entered a non-VA care consult and the non-VA provider evaluated the patient,
- Eight days elapsed between the recommended CID and the NVCC provider's evaluation of the patient,
- Twenty days elapsed between the NVCC provider requesting additional services and the patient's death, and

³⁴ VHA Directive 1232(1), *Consult Processes and Procedures*, August 24, 2016, amended September 23, 2016.

- Forty-six days elapsed between the time the NVCC provider requested additional services and the IHS provider acknowledged this request.

The OIG determined that the involved facility staff generally complied with consult processing and scheduling guidelines with the exception of the 46 days that elapsed between the time the NVCC provider entered an RAS and the acknowledgement of this request by the IHS provider. While VA lacked a policy specific to the time frame in which NVCC RASs should be addressed, the OIG team was told that the facility’s expectation was five days. The 46 days also exceeded facility expectations for timely approval of an RAS. The OIG team determined that, in this case, the time frame for the approval process exceeded that which was clinically appropriate for the medical care of the patient with an acute medical condition requiring timely intervention.

Issue 2: Alleged Failure to Timely Approve/Process NVCC Consults and Coordinate Care

In addition to reviewing the identified patient case, OIG staff conducted a broader review of NVCC cardiothoracic surgery consults in order to study the facility’s processes for timeliness and coordination of care provided through NVCC. The OIG substantiated that, other than the initial consult reviews done by the IHS physician, delays occurred in the approval and processing of NVCC consults for care.

The OIG also reviewed consult timeliness metrics available to IHS leadership at the time of the OIG’s March 2018 site visit to determine if delays in the approval and processing of NVCC consults were an ongoing problem.

Timeliness of the NVCC Consult Process

OIG Review of Timeliness

The OIG reviewed a total of 82 NVCC cardiothoracic surgery consults submitted from January 1, 2017, through October 31, 2017, to identify potential issues with timeliness or care coordination.

As shown in Table 1, the initial consult review done by the IHS physician was consistently completed in a timely manner, however, delays were identified at subsequent stages of the process.

Table 1. Timeliness of January 1, 2017, through October 31, 2017, NVCC Cardiothoracic Surgery Consults

NVCC Consult Step	Percentage Timely
Consults reviewed and moved to active status within the specified number of business days	96%

NVCC appointment within 30 days of CID	70%
Consult closed within 90 days	85%
RAS, if applicable, reviewed and approval documented within 5 business days	81%

Source: VA OIG analysis of 82 facility EHRs containing NVCC cardiothoracic surgery consults

Facility NVCC Timeliness Metrics

To determine if NVCC consult delays were an ongoing problem, the OIG reviewed consult timeliness metrics available to facility IHS leadership at the time of the OIG March 2018 site visit. As of March 13, 2018, there were 5822 open NVCC consults, 4585 of which failed to meet timeliness expectations and were considered backlogged. Per the facility, a consult was backlogged if any of the following conditions were met: consult status of “pending” greater than 2 days (less than 1 percent of the total), consult status of “active” greater than 30 days (49 percent), consult status of “scheduled” greater than 30 days (31 percent), or consult remained open greater than 90 days (19 percent). The facility did not measure the percent of appointments made within 30 days of CID or RAS timeliness.

Factors Contributing to Delays

The OIG analysis of the process used by the facility for NVCC consults was found to align with those outlined by OCC; however, the OIG found deviations from VHA directive and facility expectations in regard to the timeliness with which NVCC consults were managed. A number of factors contributing to delays were identified.

Deviation from VHA Policy

VHA Directive 1232(1) states “[t]he status of consult should be scheduled status within 14 days of date of consult order.”³⁵ The OIG review found that the facility tracked consults in active status greater than 30 days rather than 14 days. The application of a more liberal standard may have prevented the facility from identifying consults in need of action earlier thereby enabling the facility to schedule more patients within 30 days of the CID.

Attention to, and application of the CID, also deviated from expectations. VHA standards for timely care include the expectation that NVCC appointments should occur within 30 days of the CID specified in the consult. IHS staff identified common drawbacks in the reliance on CID to establish actual time frames in which services are needed. One issue noted was that CID is often identified as the same date the consult is ordered. Staff indicated referring providers may not differentiate between services for which a short CID is truly necessary and those for which it is

³⁵ VHA Directive 1232(1).

not. Indiscriminate use of “today” as the CID makes it more difficult for IHS staff to differentiate consults, which require expedited processing from those which are less time sensitive.

Increasing Demand

With the opening of the new facility at Lake Nona in February 2015, the increase in services brought an increase in community-based patient care (Choice and NVCC) consults to IHS. In May 2017, the facility reduced the degree to which Choice was used and, as a result, Choice consults were returned by the third-party administrator to the facility for final disposition/management by IHS staff.³⁶ This created an influx in the volume of work for both IHS and OCC Staff. According to staff, there were more consults coming in a day than could be managed by the available IHS and OCC staff. For the past few years, IHS received approximately 100 new consults for community-based patient care (Choice and NVCC) per day. As of May 2018, IHS was receiving approximately 200 new consults for community-based patient care (primarily NVCC) per day.

IHS and OCC Staffing

The OIG determined that the facility had limited staff to manage the increasing consult demand. In 2014, the creating of authorizations and the obligating of funds for NVCC consults moved from a facility process in IHS to a VISN process within the OCC. This was a unique structure specific to VISN 8 and included a realignment of staff. This changed the consult process in IHS; staff had to alert OCC staff in another office when an authorization was needed for a consult. In 2017, a regional centralization initiative of claims adjudication and reimbursement to improve claims processing began, which consolidated 98 claims processing locations to 13 claims processing hubs. VISN 8’s model of consolidation did not match the new regional centralization model. The regional centralization model focused on claims processing and did not include the authorization of consults. The Orlando OCC was not chosen to be a claims processing hub and, as a result, staff vacancies in the Orlando OCC were not filled. New claims staff were hired for the regional hubs and, at the Orlando OCC, work was dispersed among the remaining claim processing and authorization clerks. As of March 2018, the Orlando OCC had five clerks assigned to review and approve authorizations compared to nineteen clerks in 2017. During interviews with IHS staff and leaders, the OIG consistently heard that OCC was understaffed, and there were delays getting consults authorized and funds obligated for NVCC consults. Because the regional hub only handled claims processing, the Orlando OCC was not able to obtain assistance from the regional hubs for creating authorizations.

As of March 2018, IHS had 89 total authorized full-time employee equivalents on its organizational chart with 77 positions filled. Several key positions such as service chief,

³⁶ Facility leaders reduced the degree to which Choice was used due to national funding and third-party administrators’ high return rates for certain types of care.

administrative officer, and lead administrative support assistant were vacant for greater than a year. IHS staff and leadership reported that it had been a challenge to find qualified applicants for the lead administrative support role and to retain staff due to the high volume of work.

To help determine the number of full-time employees needed, IHS leadership considered both the 2016 Veterans Engineering Resource Center (VERC)³⁷ tool that captured the time spent on tasks and volume of work to calculate number of staff needed. In 2018, the facility populated an OCC staffing model designed to help sites determine staffing levels. Neither the VERC tool nor the OCC staffing model resulted in business plans for additional staff that could be considered by facility leadership because IHS leadership lacked confidence in the results. IHS leadership reported that the constant changes in the VA community-based patient care program are a reason that staffing shortages still have not been addressed.

Other Challenges

Facility staff identified additional factors that impacted the timeliness of the process including:

- The ability to communicate with patients in a timely manner,
- The time required to coordinate and complete tests or procedures needed prior to the NVCC visit, and
- Communication with and the availability of NVCC providers able to see patients within the desired timeframe.

Care Coordination Process

The tools used by IHS for managing consults and coordinating care were recently implemented and, while of use, they did not fully address the need to prevent a step in the patient's continuum of care from being overlooked.

IHS staff tracked the status of each consult and the coordination of care through the use of locally developed spreadsheets referred to as "trackers." The facility created a tracker for use by administrative staff and another for use by RN case managers. IHS providers did not have trackers, nor did they have access to the administrative or nursing trackers. The facility utilized locally developed trackers while they waited for a final tracking tool from OCC as local experience with early OCC tools identified inconsistencies in data.

The administrative support tracker included a listing of consults by service for the services managed and the request date of the consult, and allowed administrative staff to follow the

³⁷ "VERC centers facilitate innovative solutions to health care delivery challenges identified by national, network, and facility leadership as well as propose important opportunities for change and improvement." <https://www.pittsburg.va.gov/verc/>. (The website was accessed on June 11, 2018.)

disposition of the consult, appointment dates, and communication between the patient and community-based care provider.

The RN tracker was more sophisticated in its design with additional fields and features such as the date records were sent to the community-based care provider, the date the authorization for care expired, and a welcome page summarizing the number of cases waiting for patient contact, identification of a community-based care provider, OCC authorization, initial appointment to be scheduled, or waiting for records from the community-based care provider. The RN tracker lacked a column to capture the presence of an RAS although open text care management comment fields could be used for this purpose.

Neither of the trackers interfaced with each other and both had to be manually populated. For accountability purposes and in the event of an employee absence, each RN and administrative support assistant was responsible for managing a list of patients using an assigned tracker, but the tracker could be viewed by other IHS employees. Staff acknowledged that given the need to enter data manually, it could be challenging to keep the trackers up to date.

The OIG found that an increase in the number of consults coupled with the limited IHS and OCC staff contributed to delays in the timely management of NVCC consults at the facility. Additionally, the OIG identified problems with adherence to the intent and application of CID by referring providers and IHS staff and found that the facility lacked a mechanism to track the timeliness of RASs. Lastly, the OIG found that the absence of a fully implemented and automated tool to assist with care coordination introduced the increased possibility of disruptions in the care coordination for NVCC patients.

Issue 3: Impact of Alleged Delays on Patients

The OIG did not substantiate that delays in the approval and scheduling of NVCC consults resulted in adverse clinical outcomes for the patients reviewed.

The OIG reviewed documentation in the EHR for 82 NVCC cardiothoracic surgery consults of 73 patients to determine if patients experienced adverse clinical outcomes because of delays in approval or scheduling of NVCC consults. (See Appendix A.) Of those 73 patients, 29 experienced a delay of greater than 30 days from CID. The OIG independently reviewed the EHRs of the 29 patients identified above plus five patients with an RAS that was not acted on, or approved by, an IHS provider within five days of the request. (See Appendix A).³⁸

While the OIG did not find that the 34 patients reviewed suffered adverse clinical outcomes as a result of the delayed approval or scheduling, the OIG recognizes that there may have been

³⁸ Five of the 73 patients died during their course of care. Of those that died, one experienced a delay and was included in the group of 29 patients reviewed by the OIG team.

frustration, confusion, or disturbances in a patient's activities of daily living that resulted from these delays.

Conclusion

The OIG found that the patient referenced in this report died prior to receiving scheduled aortic valve surgery for *asymptomatic* severe aortic stenosis. During the review of the patient's care, the OIG identified an unreported anomaly in the patient's EHR. Although testing in 2016 indicated the patient's AS had progressed from moderate to severe, the EHR indicated that the patient's AS was moderate at that time. Further, the EHR did not reflect that the treating cardiologist at the time had told the patient that the AS had progressed. However, because the treatment for the patient (a follow-up visit in one year) was within the acceptable treatment options for asymptomatic severe AS, the OIG concluded that the failure to accurately record the diagnosis in the EHR did not negatively impact the patient's care.

The OIG did not substantiate that the death occurred as a result of a long delay in the approval for community-based patient care. After referral to an NVCC thoracic surgeon in 2017, facility staff complied with consult processing and scheduling timeliness guidelines except for the 46 days that elapsed between the time the NVCC provider entered an RAS and the acknowledgement of this request by the IHS provider.

The OIG substantiated delays in the approval and processing of NVCC consults for other patients referred for thoracic surgery during a 10-month period in 2017. An increase in the number of consults coupled with the limited number of IHS and OCC staff contributed to delays in the management of NVCC consults. The OIG identified problems with the providers assigning CIDs and IHS staff adhering to the assigned CIDs. Additionally, the facility lacked a mechanism to track RAS timeliness. The absence of a fully implemented and automated tool to assist with care coordination increased the possibility of disruptions in the care coordination for NVCC patients.

While the OIG did not find that the patients reviewed suffered adverse clinical outcomes due to delays in consult processing, the OIG recognizes that the delays may have caused frustration, confusion, or disturbances in a veteran's activities of daily living.

Recommendations 1–6

1. The Orlando VA Medical Center Director ensures that the nurse practitioner referenced in this report has appropriate competencies to perform current duties.
2. The Orlando VA Medical Center Director identifies and implements a reliable tool for coordinating the non-VA care coordination process and monitors the tool for consistency.
3. The Orlando VA Medical Center Director conducts a compliance review of the clinically indicated dates used by providers referring patients to Integrated Health Service to determine adherence to Veterans Health Administration Directive 1232 (1), *Consult Processes and Procedures*, and implements a plan for improvement, if warranted.

4. The Orlando VA Medical Center Director ensures that non-VA care coordination appointments are scheduled within 30 days of the clinically indicated date and monitors performance.
5. The Orlando VA Medical Center Director conducts a review of Integrated Health Services workload demand and available staff and takes action, as appropriate, to ensure staffing allows for consults to be acted upon within Veterans Health Administration consult timeliness standards.
6. The Orlando VA Medical Center Director implements a process for measuring the timeliness of approvals for requests for additional services and monitors compliance.

Appendix A: OIG Patient Case Review for Assessing Adverse Clinical Outcomes

Table A.1: Source of Patient Case Reviews and Number of Cases Identified

Source of EHR Cases for Review of Community Care	Number of Cases Identified
All Community Care cardiothoracic surgery consults January 1 through October 31, 2017	112
Non-NVCC cardiothoracic surgery consults	-30
Total of NVCC Cardiothoracic Surgery Consults Identified	82
Duplicate patient names (patients with more than one NVCC cardiothoracic surgery consult)	-9
Total Unique Patients with an NVCC Cardiothoracic Consult	73
Unique patients without identified delays (Appointment date less than 30 days of CID)	-44
TOTAL unique patient cases with identified delay in NVCC care*	29
Total of NVCC Cardiothoracic Surgery Cases Reviewed for Adverse Clinical Outcomes	34
Total unique patient cases with identified delay in NVCC care*	29
Unique patient cases with approval of RAS greater than 5 days	5
Unique patient cases with a delay who also died during their course of care and are not included in either of the above counts	0

Source: VA OIG analysis of patient electronic health records

**Appointment date greater than 30 days from CID*

Appendix B: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: November 26, 2018

From: Director, VA Sunshine Healthcare Network (10N08)

Subj: Healthcare Inspection—Delay in Processing Community-Based Patient Care, Orlando VA Medical Center, Orlando, Florida

To: Director, Seattle Regional Office, Office of Healthcare Inspections (54SE)
Director, Management Review Service (VHA 10E1D MRS Action)

1. We appreciate the Office of Inspector General's (OIG) oversight which focuses on events that occurred at the Orlando VA Healthcare System (OVAHCS), Orlando, Florida.
2. I have reviewed the OIG's draft report and concur with the recommendations as documented.
3. Additionally, I have reviewed the Medical Center Director's response including action plan and projected completions dates and I concur. VISN 8 will assist the Orlando VA Healthcare System's leadership in reaching full compliance in a timely manner.

(Original signed by:)

Miguel H. LaPuz, M.D., MBA
Network Director

Appendix C: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: November 21, 2018

From: Director, Orlando VA Medical Center (675/00)

Subj: Healthcare Inspection—Delay in Processing Community-Based Patient Care, Orlando VA Medical Center, Orlando, Florida

To: Director, VA Sunshine Healthcare Network (10N8)

Thank you for the opportunity to review the draft report of the Office of Inspector General—Delay in Processing Community-Based Patient Care at the Orlando VA Medical Center, conducted March 20–22, 2018. I have reviewed the document and concur with the recommendations. A response to each recommendation is provided in the attached report for your review.

(Original signed by:)

Timothy W. Liezert
Orlando VA Medical Center Director

Comments to OIG's Report

Recommendation 1

The Orlando VA Medical Center Director ensures that the nurse practitioner referenced in this report has appropriate competencies to perform current duties.

Concur.

Target date for completion: February 28, 2019

Director Comments

The nurse practitioner is currently under a Scope of Practice. The ANCC certification for this practitioner is in Family Practice. At the time of the pulmonary clinic visit the nurse practitioner was working in Pulmonary Medicine and has since transitioned to a new role. A review of the care provided by this nurse practitioner will be performed by a nurse practitioner within the same specialty in accordance with policy. The Scope of Practice and Ongoing Professional Practice Evaluation (OPPE) will be reviewed for any concerns by the Service Chief, Medicine in accordance with policy which will address competencies to perform current duties.

Recommendation 2

The Orlando VA Medical Center Director fully implements a reliable tool for coordinating the non-VA care coordination process and monitors the tool for consistency.

Concur.

Target date for completion: February 28, 2019

Director Comments

The Integrated Health Services (IHS), which has oversight for Community Care at the Orlando VA Medical Center, already utilizes a locally developed tracking tool to coordinate all Non-VA care processes. The Chief of IHS, with the assistance of the IHS Supervisors, will ensure 100% consistent usage of the tool and perform a review of tool usage every 2 weeks for 3 months. Additionally, the Orlando VA Medical Center IHS department will continue to work with VISN 8 in the pursuit of installing Consult Tracking Manger (CTM) software with a tentative proposed implementation in FY 2019.

Recommendation 3

The Orlando VA Medical Center Director conducts a compliance review of the clinically indicated dates used by providers referring patients to Integrated Health Service to determine

adherence to VHA Directive 1232 (1), *Consult Processes and Procedures*, and implements a plan for improvement, if warranted.

Concur.

Target date for completion: February 28, 2019

Director Comments

A retrospective review of FY 18 consults was performed by the ACOS, Ambulatory Care along with the Group Practice Manager (GPM) to determine adherence to VHA Directive 1232 clinically indicated date usage by Orlando VA Medical Center providers submitting consults to Integrated Health Services (IHS). As defined by the directive the CID chosen by the requesting provider is an independent clinical decision made by the provider based on the patient's clinical needs at the point of care moment the consult is ordered. Upon conclusion of the review the Deputy Chief of Staff in agreement with the ACOS, Ambulatory Care and the GPM concluded that there were no identifiable needs for improvement given the results and directive language indicating the provider has the sole discretion to determine the clinically indicated date. OVAMC will assemble all items used in this review including but not limited to the tool used to collect the data and an analysis of the findings and submit them to the OIG.

Recommendation 4

The Orlando VA Medical Center Director ensures that non-VA care coordination appointments are scheduled within 30 days of the clinically indicated date and monitors performance.

Concur.

Target date for completion: February 28, 2019

Director Comments

The ACOS, Ambulatory Care, in conjunction with the Chief of Integrated Health Services and/or their designee, will review 100% of the cardiology and cardiothoracic surgery consults to ensure contact with the Veteran has been made and documented in 14 days after receiving the community care consult. Note that the timeliness of scheduling Non-VA care appointments within the 30 days of the clinically indicated date is dependent upon other factors such as the availability of appointments with the community care providers, lack of a contracted network after sunset of Health Net and other community based factors.

Recommendation 5

The Orlando VA Medical Center Director conducts a review of Integrated Health Services workload demand and available staff and takes action, as appropriate, to ensure staffing allows

for consults to be acted upon within Veterans Health Administration consult timeliness standards.

Concur.

Target date for completion: February 28, 2019

Director Comments

A review of Integrated Health Services workload demand and available staff was completed on May 25, 2018 utilizing the VERC tool and staffing tool within the standard operating model of Office of Community Care (OCC). This review was based on factors that included increased workload to community care, lack of the expected decline in community referrals with the activation of clinical services at the new medical center in Lake Nona and regulatory changes that increased referrals to community care. Based on the review findings, the Orlando VA Medical Center Director approved an increase of 23 full time employees. The 23 full time employees that were approved were broken down as follows: 15 Advanced Medical Support Assistants (AMSA's), 6 Registered Nurses (RN's), conversion of 1 Administrative Support Assistant (ASA) to a supervisory program specialist, 1 management and program assistant for vendor outreach and 1 physician.

Recommendation 6

The Orlando VA Medical Center Director implements a process for measuring the timeliness of approvals for requests for additional services and monitor compliance.

Concur.

Target date for completion: February 28, 2019

Director Comments

The Chief, Integrated Health Services (IHS) will implement standardized episodes of care (SEOC's) for Cardiology and Cardiothoracic services where they are available and have been released from the Office of Community Care (OCC) to the field. This will minimize the volume of request for additional services (RFAS). While SEOC's are being implemented, a Quality Monitor will be established that involves random retrospective reviews to ensure timeliness standards are being met.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
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